MEDI-CAL UPDATE Part 2
Billing and Policy
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## Pharmacy

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**Contents**



### 2005 CPT-4/HCPCS Codes and Modifiers Update

Effective November 1, 2005, the following code and modifier conversions are taking place due to annual HCPCS updates and/or mandated HIPAA conversions:

- Conversion to the 2005 CPT-4 and HCPCS Level II codes
- Policy updates related to the 2005 CPT-4 and HCPCS Level II code updates
- ICD-9 procedure code update for inpatient providers
- HIPAA-mandated conversion of hearing aid and accessory codes and modifiers
- HIPAA-mandated conversion of interim modifiers
- HIPAA-mandated conversion of respiratory care practitioner codes

Policy for all updates were announced in the September 2005 *Medi-Cal Update*. Provider manual updates are included in this month's *Medi-Cal Update*.


### Part B Pharmacy Crossover Claims

Beginning October 24, 2005 Medi-Cal will accept Medicare Part B Pharmacy crossover claims for drugs in the HIPAA-mandated NCPDP 1.1 batch format. As a result, retail pharmacy providers or submitters who bill Medicare using the NCPDP format can stop billing the Medi-Cal portion of their crossover claims via the *HCFA 1500* paper claim form using HCPCS codes. These claims should cross over automatically from CIGNA Medicare. NCPDP claims that do not cross over automatically must be billed to Medi-Cal using the *Pharmacy Claim Form* (30-1) or the *Compound Drug Pharmacy Claim Form* (30-4) in order to accommodate the National Drug Codes (NDCs).

Payment methodology for each service on a Medicare Part B Pharmacy drug crossover claim will be calculated using the Medi-Cal rate on file for the NDC number and the quantity billed, less the Medicare payment. Medi-Cal will discontinue payment based on the coinsurance and deductible billed on the claim. This eliminates the need for Charpentier rebills and makes payment on crossover claims consistent with regular Medi-Cal.

In addition, any Medicare Part B pharmacy crossover claim for drugs submitted to Medi-Cal that should be directed to County Organized Health Systems (COHS) will be denied. These claims will not automatically transfer to a COHS for payment, as is the case for other Part B crossover claims. Providers must bill COHS separately.

*Please see* **Crossover Claims**, *page 2*

**Crossover Claims** *(continued)*

Providers or submitters not yet converted to the NCPDP 1.1 format with Medicare must continue billing the Medi-Cal portion of crossover claims that fail to cross over automatically with the *HCFA 1500* paper claim form using HCPCS codes (not NDCs).

For new crossover claim billing instructions and examples, please refer to the *Medicare/Medi-Cal Crossover Claims: Pharmacy Services* section of the Part 2 Pharmacy manual. For COHS billing instructions please refer to the *MCP: County Organized Health System (COHS)* section of the Part 1 manual.

For more information, call the Telephone Service Center (TSC) at 1-800-541-5555. Select the appropriate language and press the following option numbers:

- 14 (this option includes Medicare/Medi-Cal crossover claims), then
- 11 (this option is specific to Medicare/Medi-Cal crossover claims)

*These changes are reflected on manual replacement pages medi cr ph pr 1, 2, 4 and 5 (Part 2), medi cr ph pr 1 and 10 thru 14 (Part 2) and cif sp 4, 5, 7 and 8 (Part 2).*

### Rate Adjustment for Thoracic-Lumbar-Sacral Orthoses (TLSO)

Retroactive to dates of service on or after September 22, 2003, the maximum allowance for HCPCS code L0486 (TLSO, triplanar control, two piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated) is increased to $1,354.09. Providers who submitted claims for code L0486 for dates of service on or after September 22, 2003 do not need to resubmit a claim. Claims will be automatically reprocessed.

*These changes are reflected on manual replacement page ortho cd1 3 (Part 2).*

### Rate Adjustments for Selected Orthotic & Prosthetic (O & P) Appliance Codes

Effective for dates of service on or after November 1, 2005, reimbursement rates will be adjusted for the following O & P appliance codes:

- L3140 and L3150 (abduction and rotation bars)
- L3300 and L3310 (shoe modification - lifts)
- L3530, L3540, L3550 and L3570 (miscellaneous shoe additions)
- L3610 (transfer or replacement)
- L3911 (custom fitted wrist-hand-finger orthosis)

Please refer to the *Orthotic and Prosthetic Appliances* section in the appropriate Part 2 manual for a list of O & P appliance HCPCS codes and maximum allowances for these codes.

*These changes are reflected on manual replacement pages dura bil dme 9 (Part 2) and ortho cd1 17 thru 20 and 22 (Part 2).*

### Durable Medical Equipment (DME) for California Children's Services (CCS) Clients

The following Durable Medical Equipment (DME) codes are allowed only for California Children's Services (CCS) clients and require authorization by the CCS program:

| HCPCS Code | Description |
|---|---|
| A4606 | Oxygen probe for use with oximeter device, replacement |
| E0445 | Oximeter device for measuring blood oxygen levels non-invasively |
| E0463 * | Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface (e.g. tracheostomy tube) |
| E0464 * | used with non-invasive interface (e.g. mask) |
| E0481 | Intrapulmonary percussive ventilation system and related accessories |
| E0482 | Cough stimulating device, alternating positive and negative airway pressure |
| E0635 | Patient lift; electric, with seat or sling |
| E0639 * | Patient lift, movable from room to room with disassembly and reassembly, includes all components/accessories |
| E0640 * | Patient lift, fixed system, includes all components/accessories |

* Effective for dates of service on or after November 1, 2005. Other codes listed are currently effective.

*This information is reflected in a new provider manual section, Durable Medical Equipment (DME): Billing Codes for California Children's Services (CCS) (Part 2).*

# Instructions for Manual Replacement Pages — Part 2

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| | |
|---|---|
| Remove and replace: | *Contents for Pharmacy Billing and Policy iii/iv* * |
| | appeal form 1/2 **, 7/8 ** |
| | blood 7/8 * |
| | cal child ser 7/8 * |
| | children 1 thru 4 ** |
| | cif sp 3 thru 8 |
| | dura 11/12 * |
| | dura bil dme 3 thru 8 *, 9/10 |
| | dura bil oxy 7/8 * |
| Remove: | dura cd 3 thru 23 |
| Insert: | dura cd 3 thru 24 * (new) |
| Insert new section after Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates: | dura cd ccs 1 |
| Remove and replace: | dura cd fre 1 thru 4 * |
| | medi cr ph 1 thru 6 |
| | medi cr ph pr 1/2 |
| Remove: | medi cr ph pr 9 |
| Insert: | medi cr ph pr 9 thru 14 (new) |
| Remove and replace: | medi non hcp 1/2 * |
| | ortho cd1 3/4, 5/6 *, 9 thru 16 *, 17 thru 22, 25/26 * |
| | ortho cd2 5 thru 10 *, 15 thru 22 * |
| | ortho ex 5/6 * |
| | pcf 30-1 comp 9/10 ** |
| | share ph 5/6 ** |
| | sub acut lev 3/4 ** |
| | tar field 1/2 ** |
| | tax 1 thru 8 * |

* Pages updated due to ongoing provider manual revisions.

** Pages updated due to ongoing provider manual revisions. County Medical Services Program (CMSP) providers should remove these pages but retain them in the Appendix of their provider manual for future reference.